



**GUAM PUBLIC HEALTH LABORATORY**  
**DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES**  
 761 South Marine Corps Drive, Tamuning, Guam 96913  
 Telephone: (671) 300-9085/9096/9097/9098 Fax: (671) 300-9989

GPHL LABORATORY NUMBER

DATE RECEIVED

(PLEASE TYPE INFORMATION AND OR PRINT LEGIBLY)

<b>ORDERING/PRIMARY PHYSICIAN:</b> Robert Leon Guerrero, M.D. or designee		<b>I. PATIENT IDENTIFICATION</b>	
ADDRESS: TIYAN OUTREACH		LAST NAME	
Street: 520 WEST SANTA MONICA AVENUE		FIRST NAME AND MIDDLE INITIAL	
City: DEDEDO State: GUAM		RESIDENT ADDRESS (Physical place of residence Street, City, Zip Code)	
Country: USA Zip Code: 96929		Street:	
Phone No.: (671) 635-7525		City:	
SUBMITTING LABORATORY:		Zip Code:	
ADDRESS:		PHONE NO.:	
Street:		Cell/Mobile: Home: Work:	
City: State:		EMPLOYER / OCCUPATION ETHNICITY DATE OF BIRTH SEX	
Country: Zip Code:		(e.g. Chamorro, Filipino, etc.)	
Phone No.:		LABORATORY EXAMINATION REQUESTED	
CLINICAL DIAGNOSIS		COVID-19/SARS-COV-2-PCR	
CATEGORY OF AGENT SUSPECTED		SPECIFIC AGENT SUSPECTED	

<b>II. SPECIMEN INFORMATION</b>		<b>III. CLINICAL HISTORY</b>	
1. SOURCE OF SPECIMEN <input checked="" type="checkbox"/> HUMAN <input type="checkbox"/> OTHER (Specify): _____		1. CLINICAL SIGNS AND SYMPTOMS <input type="checkbox"/> FEVER <input type="checkbox"/> EXANTHEMA (Specify Type): _____ <input type="checkbox"/> RESPIRATORY SIGNS: _____ <input type="checkbox"/> CENTRAL NERVOUS SYSTEM INVOLVEMENT: _____ <input type="checkbox"/> GASTROINTESTINAL INVOLVEMENT: _____	
2. ORIGINAL MATERIAL TYPE OF SPECIMEN (SPECIFY SITE OF COLLECTION): NASOPHARYNGEAL DATE AND TIME OF COLLECTION: _____ TRANSPORT MEDIUM: _____ COLLECTED BY (PRINT NAME): RN/LPN/CNA		2. ADDITIONAL INFORMATION TRAVEL HISTORY: _____ IMMUNIZATIONS: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Pfizer 1st Dose 2nd Dose <input type="checkbox"/> Moderna 1st Dose 2nd Dose <input type="checkbox"/> Janssen Single Dose ANTIBIOTIC THERAPY: _____	
3. SEROLOGY OF SPECIMEN COLLECTION DATE: <input type="checkbox"/> ACUTE (S1): _____ <input type="checkbox"/> CONVALESCENT (S2): _____ <input type="checkbox"/> S3: _____ <input type="checkbox"/> S4: _____ <input type="checkbox"/> OTHER (Specify): _____		4. SEROLOGY OF SPECIMEN <input type="checkbox"/> PURE ISOLATE <input type="checkbox"/> MIXED CULTURE <input type="checkbox"/> OTHER (Specify): _____ DATE OF ORIGINAL CULTURE: _____ PRIMARY ISOLATION MEDIA: _____ COLLECTON SITE OF ORIGINAL SPECIMEN: _____ DATE OF CULTURE SUBMITTED AND TRANSPORT MEDIUM USED: _____ SUSPECTED IDENTIFICATION: _____ OTHER ORGANISMS FOUND: _____ OTHER INFORMATION: _____	

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Assay: \_\_\_\_\_

Result: \_\_\_\_\_

DATE OF REPORT: \_\_\_\_\_ REFERENCE VALUES: NEGATIVE OR NOT DETECTED

3. PREVIOUS LABORATORY RESULTS/OTHER INFORMATION

The instrumentation used to conduct the test has significant sensitivity. Nevertheless few negative results should be treated with caution. Patient follow up and repeat testing, if clinically indicated, are recommended.

Patient Last Name: \_\_\_\_\_ Patient First Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_



**COVID-19 Form for Testing/Outreach/Mass Screening**

Date of onset: \_\_\_\_\_ (if symptomatic) Date of travel: \_\_\_\_\_ (if history stated)

**During this illness, did the patient experience any of the following symptoms?**

SYMPTOMS	YES	NO
Fever >100.4F (38C)	<input type="checkbox"/>	<input type="checkbox"/>
Subjective fever (felt feverish)	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>
Muscle aches (myalgias)	<input type="checkbox"/>	<input type="checkbox"/>
Runny nose	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Cough (new or worsening)	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sense of smell or taste or appetite	<input type="checkbox"/>	<input type="checkbox"/>
Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/weakness	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>

**Does the patient have any pre-existing medical conditions?**

CONDITION	YES	NO
Chronic lung disease (asthma, emphysema, COPD)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension only (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>
Chronic renal disease (ESRD/CRI)	<input type="checkbox"/>	<input type="checkbox"/>
Chronic liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Immunocompromised condition (cancer, chemo, lupus, HIV etc).	<input type="checkbox"/>	<input type="checkbox"/>
Neurological/neurodevelopmental/intellectual disability	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Current Smoker	<input type="checkbox"/>	<input type="checkbox"/>
Former smoker	<input type="checkbox"/>	<input type="checkbox"/>
For Females, is patient currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>

Contact with another lab-confirmed COVID-19 patient? Yes  No

Type of Contact:  Household  Community  Workplace  Healthcare

Previous COVID-19 testing? Yes  No  If "Yes", Date of collection: \_\_\_\_\_ Result: \_\_\_\_\_

Name of Interviewer: Last \_\_\_\_\_ First \_\_\_\_\_

Date of Interview: \_\_\_\_\_